STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145471	A. BUILDING ______ B. WING ______	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEBELLO HEALTHCARE CENTER	**1599 KEOKUK STREET HAMILTON, IL 62341**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey An extended survey was conducted Complaint 1122816/IL54478 - No Deficiency	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		10/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to notify the physician of the development of new pressure ulcers for one of five residents (R18) with pressure ulcers on the sample of 16

Findings include:

R18's admission face sheet indicates R18 was admitted on 8/5/11. Nursing Admission Assessment dated 8/5/11 marks an area on R18's coccyx of 1.5 cm (centimeter) x (by) 1 cm. MDS dated 8/15/11 states R18 had one stage two pressure area.

The Medical Nutritional Therapy Assessment dated 8/5/11 (on admission) notes the following: Skin condition: Pressure Ulcer Right Intragluteal Cleft.

Admission sheets from R18's transferring facility dated 7/1/11 through 7/31/11 note a treatment to the Right Ischial Tuberosity daily (pressure ulcer hydrocolloid dressing) to protect.

At 2:50 pm on 9/8/11, E5 (MDS/Minimum Data Set Coordinator) stated, "The MDS is correct, (R18) was admitted with a pressure sore on her coccyx. (R18) has a (hydrocolloid dressing) on it for protection."

E34 (LPN/Licensed Practical Nurse) and E36 (CNA/Certified Nursing Assistant) were removing

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F 157	Continued From page 2 R18's pants on 9/9/11 at 9:40 am. There was no dressing noted on R18's right gluteal fold, ischial tuberosity, or coccyx as described in the medical record. At 10:15 am on 9/9/11, Z4 (Z3's/R18's Medical Doctor's Medical Assistant) stated, "We got one notice on 8/5/11 of a pressure area to the right ischial tuberosity. There are no other calls. The doctor (Z3) hasn't seen (R18) yet." A policy on change of condition was requested from E1 (Administrator) on 9/8/11. E1 did provide a booklet on 9/9/11 titled "Interact" and stated, "This is our training manual. It is all we have. It is a great tool." The booklet did not provide a policy..	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		10/18/11

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to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure staff immediately reported two of four allegations of abuse involving four of 16 residents (R12, R13, R14, and R16) on the sample immediately to the administrator; failed to notify the state agency of one of four allegations of abuse or neglect involving four of 16 residents (R12, R13, and R14) on the sample; and failed to report a significant medication error for one of 16 residents (R2) on the sample of 16.

Findings include:

A policy dated March 2009 titled Abuse and Neglect Prohibition states, "...Reporting and Responses: 1. The facility will report all allegations and substantiated occurrences of

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abuse, neglect, and misappropriated of property to the state agency...."

1. A facility investigation dated 2/12/11 indicates an allegation of resident neglect was investigated after administration received an undated hand written note from E11 (CNA/ Certified Nursing Assistant) stating when E11 (CNA) came on duty on 2/12/11, R12 was fully clothed and saturated with urine and not hooked up to a body alarm. E11 (CNA) also indicated that same evening R13 had bowel movement on R13's scrotum and penis, and R14 was fully clothed with dried bowel movement on R14's bottom. An investigation was conducted on 2/14/11 and 2/15/11, as indicated by typed and written statements signed by E13 (CNA), E14 (CNA), E15 (CNA), E16 (LPN/Licensed Practical Nurse), E17 (CNA), E18 (LPN), E19 (LPN), and E20 (CNA). The investigative file for the 2/12/11 allegation of neglect does not include a summary of the investigative actions or findings. The investigative file also does not include verification of state agency notification of the 2/12/11 allegation. In-service Monthly Attendance Forms dated 2/09/11, 2/10/11, and 2/11/11 show forty-three staff attended in-services titled Abuse Neglect Reporting. E11 (CNA) name is not on the in-service attendance sheet indicating E11 (CNA) did not attend the Abuse Neglect Reporting in-service.

On 9/07/11 at 10:15 a.m., E1 (Administrator) stated the allegation of neglect was received on 2/14/11 after E12 (Previous Administrator) found E11's (CNA) hand written note under E12's office door on Monday morning (2/14/11). E1 (Administrator) indicated 2/12/11 was E11

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F 225	Continued From page 5 (CNA's) last night working for the facility. E1 (Administrator) reported the conclusion of the investigation was the allegation was unfounded. On 9/08/11 at 11:50 a.m., E1 (Administrator) stated E1 had just learned the Abuse and Neglect Prohibition policy dated March/2009 is not the most current policy. E1 (Administrator) stated E1 had not been aware the policy had been updated and is not certain the revised policy has been in-serviced with staff. In-service Attendance Forms show the Abuse and Neglect policy dated March 2009 was in-serviced to the staff on 8/26/10, 9/22/10, 2/09/11, 5/04/11, and 6/16/11. A revised Abuse and Neglect Prohibition policy dated February 2010 contains only one additional statement from the March 2009 policy and it was regarding investigations stating: "Any employee alleged to be involved in an instance(s) of abuse and/or neglect will be suspended immediately and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated." 2. A hand written statement dated 4/28/11 and signed by E23 (CNA/Certified Nursing Assistant) states, "...(R15's) call light was on. (E23/CNA) asked (E24/CNA) to help (E23). (R15) turns the call light on for (R16). (E24) said (E24) was just down there. While (E24) was helping (E23), (E24) said, 'I don't know why we're are getting her up. (R16) will be wet anyway.' While (E23 and E24) were getting (R16) on the toilet, (R16) didn't set on the toilet right....(E24) said, 'Damn it (R16) stand up.' ... (E23 and E24 then) took (R16) to bed. (E23 and E24) got (R16) too far down in the bed (during transfer). (E23) said let's pull (R16) up and (E24) said no we'll just pull the pillow	F 225		

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down to (R16's) head. (E24) left the room and (E23) pulled (R16) up by myself (E23)... (R15/R16's roommate) said (R15) thought (E24) was a little short with (R16). (E23) went to (E22/RN/Registered Nurse) and reported the incident..."

An abuse allegation investigation file dated 4/28/11 includes a Concern From signed by E22 (RN) and dated 4/28/11. The Concern Form states, "(E23 and E24 - Both CNAs) were changing (R16) and when transferring (R16) (E24) said, 'God damn it (R16) stand up.' Then (E24) proceeded to say that (E24's) sick of the shit and (R16) not wanting to help." The back of the Concern Form is titled Action and has been filled out by E21 (Previous DON/Director of Nursing). The Action portion of the Concern Form states: "Interviewed (E23) 4/28/11 at 10:50 a.m."

A Disciplinary Action Record in the investigation filed dated 4/28/11 indicates E22 (RN) was issued a "Final Written Warning". The disciplinary report states E22 (RN) completed a concern form regarding the 4/28/11 allegation and left the form under (E21's/Previous DON's) office door and did not immediately notify the DON or Administrator.

A typed written investigation summary written by E1 (Administrator) dated 4/29/11 indicates the incident occurred "around 3:00 a.m. to 4:00 a.m." The investigative summary shows E24 (CNA) was suspended pending the conclusion of the investigation. During the investigation, E23 (CNA), E22 (RN), R15 (R16's roommate) and R16 were interviewed. The report states R16 did

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F 225	Continued From page 7 not recall the incident but R15 (R16's roommate) did. R15 reported she heard (E24) say to (R16) 'stand up damn it!'. R15 reported E24's tone of voice was very rough and (R15) was very upset by it. A final investigative report dated 4/28/11 to the state agency states, "...Thoroughly investigated...does substantiate verbal abuse by (E24). (E24) has been terminated..." On 9/07/11 at 10:15 a.m., E1 (Administrator) stated E22 (RN) put the report regarding resident abuse under E21 (Previous DON's) office door, and E21 (Previous DON) was not contacted by phone regarding the abuse allegation. E1 (Administrator) indicated (E1) first became aware of the incident when E21 (Previous DON) informed (E1) of finding the report under (E21's) office door the morning of 4/28/11. The Abuse and Neglect Prohibition policy dated March 2009 does not include direction for staff to immediately notify the Administrator of all allegations of abuse, neglect, or mistreatment. An unsigned Body Check Worksheet dated 4/28/11 indicates R16 was assessed for potential injuries at 7:00 a.m. Investigative interviews show administration was not notified of the abuse allegation and no steps were taken to assure R16's protection from further potential abuse for at least three hours after the incident occurred. Time keeping records show E24 (CNA) finished the shift and worked until 6:13 a.m. on 4/28/11. 3. Facility incident report dated 7-2-11 stated the following: "Resident (R2) was actively dying. (R1) became restless and was grimacing upon movement. (E33/R2's physician) was notified and order was given for 2 mg (milligrams) of P.O. (orally) Morphine Sulfate every 15 min (minutes)	F 225		

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F 225	Continued From page 8 until pain subsides. Medication available was 20 mg/ml (milligrams/milliliter). Medication administered was 2 ml which was equal to 40 mg. (E33) was notified of medication variance and order was received for Narcan 0.4 mg prn (as needed) for respiratory depression. Family was at bedside and requested that Narcan not be given. (E33) was aware and instructed nurse to keep order and administer if family changed their minds." On 9-13-11 at 1:10 pm, E33 (R2's physician) stated the following: E33 was called because R2 was having trouble breathing and R2's family wanted comfort measures only for R2. E33 ordered 2 mg of Morphine Sulfate but the nurse gave 40 mg of Morphine instead. E33 ordered Narcan to reverse the effects of the Morphine. R2's family refused the Narcan. E33 was unable to say if the excess Morphine hastened R2's death. On 9-9-11 at 11:15 am, E1 (Administrator) stated E1 did not report the incident to the State Agency based on advise from the facility's legal department.	F 225		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 248		10/18/11

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F 248	Continued From page 9 Based on observation, record review, and interview, the facility failed to provide activity programs to meet the interests and psychosocial needs of one of five residents (R10) sampled for activities on the sample of 16. Findings include: The September 2011 Activity schedules lists for 09/06/2011 at 10:00AM Sharing Memories (front room), 02:00PM Spa Day (Nails), 03:00PM Afternoon Tea (or Coffee) Social. The activity schedule for 09/07/2011 lists 10:00AM Card Games (Dining Room), 02:00PM Church Service, 03:00PM Afternoon Tea (or Coffee) Social. On 9/07/11 at 02:00PM., R10 stated, "I don't get invited to the activities anymore. I told them a few times I didn't want to go, so now they never invite me. I didn't know about the church service today. I would have liked to go to that. I would like to do something besides sit in this room." Observations of R10 included 09/06/2011 at at 10:00AM, 02:00PM, 03:00PM sitting in his room alone; 09/07/2011 at 10:00AM, 02:00PM, 03:00PM sitting in his room alone. E28, Activities Assistant stated 09/08/2011 at 11:10AM, " I asked him to come the other day, he was sleeping and didn't hear me. I can't say why he doesn't come."	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		10/18/11

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F 280	Continued From page 10 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to revise the care plan for one of four residents (R4) at risk for pressure ulcers on the sample of 16. Findings include: On 9/8/11 at 11:05 am, E27 (RN/Registered Nurse) and E30 (CNA/Certified Nurse Aide) were preparing R4 for treatments on R4's pressure ulcers on the bilateral heels. E27 (RN) measured the ulcer on R4's outer left foot as 6 cm long by 4 cm wide with the depth undeterminable. The ulcer was dark purple and black with some fluid noted above the discoloration. E27 (RN) began to apply the dressing. A black area was slightly visible on	F 280		

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the opposite side of the left heel. E27 (RN) was then asked to turn R4 so that the opposite side could be observed for any other ulcers. E27 (RN) stated, "No, there aren't any other areas." Upon turning R4, a second ulcer was observed on the inner lateral area of the left heel. E27 (RN) stated, "Well, there is another one." E27 (RN) measured the area as 5 cm long x 3.3 cm wide with undeterminable depth. The area was purple and black with some fluid filled areas noted. E27 (RN) then removed the dressing from the right heel. The pressure ulcer appeared to be approximately 7 cm x 6 cm. E27 (RN) and E30 (CNA) were asked to roll R4 over to observe the lateral side of the right foot. E27 (RN) stated, "I'm sure there are no others." Once turned, a fourth area, black in color, approximately dime size, was noted to the lateral aspect of the right foot. E27 (RN) measured the area as 1 cm x 1 cm with depth undeterminable. E27 (RN) stated, "Not on the treatment sheet. It only has two areas."

R4's nursing notes contain a change of condition form dated 8/21/11. It reports at 9:15 am on 8/21/11 an area measuring 2 cm (centimeters) by 1 cm on resident's left heel. The center of the area is dark purple and the area around it is dark red. No warmth or swelling noted at the site." On 8/27/11, six days later, a second change of condition form was completed which notes pressure ulcers on bilateral heels were reported to E33 (R4's Medical Doctor) on 8/27/11. The nursing note of 8/29/11 at 3:00 pm, reports a new order was received from E33 (R4's Medical Doctor) for a treatment of a "preparation pad" wipe to the areas. None of this information could be found on the care plan.

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F 280	Continued From page 12 The facility policy titled, "Skin Management", dated February 2010, notes the following: "17. The nurse will assure that treatments, interventions, Care Plan and appropriate skin documentation records are initiated in a timely manor. 18. Pressure ulcers are measured and staged weekly." A pressure ulcer risk predicting tool dated 8/19/11 notes R4 to score a mild risk at 17 in a scale of 15-18 being mild. The 8/20/11 care plan for R4 indicates only a potential for pressure ulcers. The care plan has not marked the following approaches as required: 1) Actual pressure ulcers. 2) Measure and state wound weekly using the pressure ulcer healing assessment form. and 3) Pressure ulcer treatment as ordered. On 9/19/11 at 12:30 pm regarding adding the pressure ulcers to R4's care plan, E5 (Care Plan Coordinator) stated, "I don't know."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to administer medications as ordered by the attending physician to one of 16 residents (R2) on the	F 282		10/18/11

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F 282	Continued From page 13	F 282		

sample of 16 and to one resident (R19) in the supplemental sample.

Findings include:

1. A Medication Administration Record (MAR) dated 8/30/11 shows R19's 8:00 a.m. dose of Isosorbide Mono ER (a nitrate - medication for chest pain) 60 milligram (mg) was initialed indicating the medication was administered however on 9/06/11, 9/07/11, 9/08/11, 9/09/11, and 9/10/11 the nurses' initials for those dates have been circled. On 9/08/11 just below the circled initials for the 8:00 a.m. dose are initials with the time of 5:00 p.m. written in indicating the medication was administered. The back of R19's MAR under Medication Notes there is an entry dated 9/10/11 at 8:00 a.m. stating R19's Isosorbide Mono ER is "not available."

On 9/13/11 at 1:20 p.m., E32 (LPN/Licensed Practical Nurse) stated, "I didn't have it (Isosorbide Mono ER) last Thursday (9/08/11) so I called (Z2/R19's family member) and (Z2) did bring it in that afternoon and the evening nurse gave it. I (E32) can't tell you why it was circled on the 9th and the 10th (9/09/11 and 9/10/11). It was here. If I see a medication circled (on the Medication Administration Record) that means it wasn't given...We're are suppose to circle it and write on the back of the MAR (Medication Administration Record) why it wasn't given."

On 9/13/11 at 11:15 a.m., R19 was alert, talkative and lying in bed. R19 denies any concerns about not receiving his ordered medications.

2. A telephone order dated 6-8-11 for R2 states

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F 282	Continued From page 14 "Zoloft 25 mg (milligrams) PO (by mouth) daily." R2's POS (Physician's Order Sheet) for 6/2011 states Zoloft 25 mg PO daily. Most doses dated 6-9-11 through 6-30-11 are circled as not given. On the back of the MAR (Medication Administration Record) for dates 6-9-11 through 6-16-11 it states "not available" for the reason the medication was not given. From 6-17-11 through 6-30-11, the medication was initialed 14 times, and not circled four of the 14 times. On 9-13-11 at 11:15 am, E1 (Administrator) stated E1 was not here at the time and does not know why the medication was not obtained/or given. On 9-15-11 at 10:00 am, E2 (DON/Director of Nursing) stated E2 was not here at the time or was new and does not know why the Zoloft was not given. E2 stated if a medication is not available, the nurse should contact pharmacy and arrange to get the medication. E2 also stated the physician should be notified if it continues to be unavailable. On 9-15-11 at 10:05, E34 (LPN/Licensed Practical Nurse) stated she did initial and circle the medication on the MAR but does not remember why the medication was unavailable/not given. Facility's pharmacy agreement dated 10-7-05 states "In the event the Pharmacy cannot furnish an ordered medication on a prompt and timely basis, the Pharmacy will make arrangements with another pharmacy supplier in a community local to the Facility to promptly and timely provide such service(s) to the Facility."	F 282		

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F 282	Continued From page 15 Nursing notes dated 6-17-11 at 5:30 am show R2 was sent to the local hospital after a fall. Hospital records for 6-17-11 show R2 had lacerations to the head and face. Hospital records show R2's blood pressure was measured at 192/78 and 202/77 about 3:00 am. Doctor's hospital notes state ... verified B/P (blood pressure) is not in normal limits of pt. (patient)." R2's physician's orders contains a telephone order dated 6-17-11 at 8:00 pm which states "2 mg (milligrams) Clonidine transdermal patch" a medication used to treat high blood pressure. The order does not contain any time for administration or duration. On 6-20-11 at 1:00 pm a telephone order stating "Clarification: Clonidine 0.2 mg (milligrams) transdermal patch. Change patch q (every) 7 days." The MAR (Medication Administration Record) only contains the Clonidine 0.2 mg patch order first given on 6-20-11. These records indicate R2 did not receive the ordered Clonidine from 6-17-11 to 6-20-11. On 9-14-11 at 2:30 pm, E1 (Administrator) stated she did not know why the Clonidine order was not clarified sooner and given to R2.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		10/18/11

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F 314	Continued From page 16 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to identify new pressure ulcers, failed to monitor and promote healing of pressure ulcers, failed to notify the physician of the need for revisions of treatment for one of one residents (R4) who acquired pressure sores in the facility, and failed to monitor, evaluate, and treat one of three residents (R18) admitted with pressure ulcers on the sample of 16. R4 developed four unstageable pressure sores while residing in the facility. Findings include: 1. R4's admission face sheet dated 2/12/10, indicates R4 to be 88 years of age with Diagnoses including: Esophogeal Reflux, Anxiety, and History of Fractured Neck of Femur. R4's MDS (Minimum Data Set) dated 8/27/11 notes R4 to be moderately impaired in cognition. The MDS reports no current pressure ulcers. The 8/20/11 care plan for R4 indicates a potential for pressure sores. It does not document any current pressure ulcers. A pressure ulcer risk predicting tool dated 8/19/11 notes R4 to score a 17. The tool scores R4 a mild risk at 17 in a scale of 15-18. The facility weekly pressure ulcer log provided by the facility as current and dated August 2011 includes R4 as having a pressure ulcer on both the right and the left heel.	F 314		

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R4's nursing notes contain a change of condition form dated 8/21/11. The form reports to E33 (R4's medical doctor) a bruise on the left heel that hurts when putting on a shoe. The assessment states: "(R4) appears normal for self." the form states at 9:15 am on 8/21/11 an area measuring 2 cm (centimeters) by 1 cm on R4's left heel. The center of the area is dark purple and the area around it is dark red. No warmth or swelling noted at the site. (R4) complains of pain when area is touched. Will continue to monitor." No response was received observed from E33. No documentation from staff that E33 was contacted again that day.

On 8/27/11, six days later, a second change of condition form is noted. This form reports pressure sores on bilateral heels were reported to E33 (R4's Medical Doctor) at 4:00 pm on 8/27/11. The nursing note of 8/29/11 at 3:00 pm, two days after reporting bilateral pressure ulcers and eight days after reporting a bruise to the left heel, states a new order was received from E33 (R4's Medical Doctor) for a treatment of a "preparation pad" wipe to the areas. E27 (RN/Registered Nurse) was asked on 9/7/11 at 2:00 pm why there was a two day delay after E27 (RN) notified the physician of the pressure ulcers. E27 (RN) replied, "I don't know why, but I do know (E33) was here in the room across from (R4) that weekend with his family. Oh, and that preparation pad for (R4's) heels, is used to toughen the skin. I think it is too late for that. I will let you know when I get the supplies to do his treatment." E27 (RN) did not return this day with any notification.

A weekly pressure ulcer record reports the date of onset to the outer right heel as 8/27/11. It then

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F 314	Continued From page 18 documents an assessment on 8/29/11 which reads: "Outer right heel measures 4 cm (centimeters) x 3 cm bright read to dark purple with blister on top and unable to obtain depth. Boots applied when up in wheelchair." Also documented for 8/27/11 is an area to the left outer heel: "Area 4 cm x 3.5 cm with 0.1 cm depth open with serous drainage. (R4) moving feet on bed. Boots applied when in wheelchair." On 9/8/11 at 11:05 am E27 (RN/Registered Nurse) and E30 (CNA/Certified Nurse Aide) were preparing R4 to do treatments on R4's bilateral heels. E27 (RN) stated, "Here is the current treatment sheet for (R4). I didn't get to this yesterday, but they did have (E35/LPN/Licensed Practical Nurse) measured (R4's) ulcers last night (9/7/11). Now (R4) has a new order for antibiotic ointment to the ulcer on the right outer heel because it has opened up." The padded protected boot was removed from R4's left foot. The gauze dressing was off of the ulcer located on the heel and was approximately three inches above R4's ankle. The ulcer was was not covered. E27 (RN) measured this ulcer as 6 cm long by 4 cm wide with the depth undeterminable. The ulcer was dark purple and black with some fluid noted above the discoloration. E27 (RN) began to apply the dressing. A black area was slightly visible on the opposite side of the left heel. E27 (RN) was then asked to turn R4 so that the opposite side could be observed for any other ulcers. E27 (RN) stated, "No, there aren't any other areas." Upon turning R4, a second ulcer was present on the inner lateral area of the left heel. E27 (RN) stated, "Well, there is another one." E30 (CNA) rolled his eyes and stated, "He (R4) used to wear shoes before this happened."	F 314		

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F 314	Continued From page 19 E27 (RN) measured the area as 5 cm long x 3.3 cm wide with undeterminable depth. The area was purple and black with some fluid filled areas noted. E27 (RN) wiped the area. Serosanguinous drainage was present on the wipe. E27 (RN) then removed the dressing from the right heel. The area had some black necrotic tissue at the edge of an open area, in addition to dark purple, dark red, and some fluid filled areas on top of the discolored areas. The entire area appeared to be approximately 7 cm long x 6 cm wide. E27 (RN) and E30 (CNA) were asked to roll R4 over to observe the lateral side of the right foot. E27 (CNA) stated, "I'm sure there are no others." Once turned, a second area, totally black in color, approximately dime size, was noted to the lateral aspect of the right foot. E27 (RN) measured the area as 1 cm x 1 cm with depth undeterminable. E27 (RN) stated, "(E35/LPN/Licensed Practical Nurse) was told to measure these last night (9/7/11) after you had asked to see them." E35 (LPN) documented on a weekly pressure ulcer record, dated 9/7/11, "Area to the outer right heel as going from 4 cm x 3 cm on 8/29/11 to 6 cm x 7 cm on 9/7/11. Included in the area is an open area measuring 1.3 cm x 2 cm. Treatment received to use (antibiotic ointment) and dressing two times daily." E27 (RN) was asked if E35 (LPN) had found and measured the two new areas. E27 (RN) stated, "Not on the treatment sheet. It only has the two areas." E35 (LPN) stated on 9/8/11 at 2:05 PM, "I've only been here three days. I was just told to measure (R4's) sore on the one foot and nobody else. It was just one area."	F 314		

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During interview with E2 (DON/Director of Nursing) on 9/9/11 at 10:10 am, E2 (DON) stated, " I did an investigation and I believe that (R4's) family brought in some cheap shoes that didn't fit right."

Z1 (E33/R4's Medical Doctor's Nurse) stated, "There were four pressure sores to start with. I don't have any dates but our first order was for (antibiotic ointment) for (R4) on September 1st or 2nd and then an order for a skin preparation to toughen the skin." Z1 was informed that the facility documented a change of condition notice dated 8/21/11 of a bruise to the left heel and another change notice dated 8/27/11 for pressure ulcers to R4's bilateral heels, one each. Z1 stated, "Oh, yes, but that probably wasn't a bruise on the first heel since the next was pressure sores." Z1 was asked why it took two more days to get a treatment order for the ulcers requested on 8/27/11 and received on 8/29/11. Z1 stated, "The doctor (E33) was off on vacation from 8/22/11-8/26/11. (E33) is the medical director, he does take call for himself but he was off somewhere that he had no reception on his phone. I really can't give you any other dates about how or when the sores developed."

The 8/1/11 to 8/31/11 treatment administration includes orders dated 8/29/11 to apply (skin preparation pad) treatments to bilateral heels BID (two times a day). The treatment sheet shows that the treatment was not begun until 8/31/11, four days after the doctor was notified of bilateral pressure ulcers to the heels and ten days after the first change of condition documentation for the left heel.

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2. R18's admission face sheet dated 8/5/11 indicates that R18 is 68 years of age with Diagnoses including: Diabetes, Cerebral Palsy and History of Septic Right Hip. R18's MDS dated 8/15/11 reports R18 to have one stage two pressure ulcer. Interim care plan for R18 dated 8/5/11 states "Wound will show signs of healing with area decreasing in overall size and depth by next review." Nursing Admission Assessment dated 8/5/11 marks an area on R18's coccyx of 1.5 cm (centimeters) x (by) 1 cm. It includes a pressure sore risk tool that scores her a 16 for a total score equally 15-18 as a mild risk. The Medical Nutritional Therapy Assessment dated 8/5/11 (on admission) notes the following: Skin condition: Pressure Ulcer Right Intragluteal Cleft. Admission sheets from R18's transferring facility dated 7/1/11 through 7/31/11 note a treatment to the Right Ischial Tuberosity daily (pressure ulcer hydrocolloid dressing) to protect.

A weekly pressure ulcer record dated 8/5/11 notes a stage II area on the "coccyx admit" measures 1.5 cm x 1 cm open area.

R18's treatment record for 8/1/11 through 8/31/11 includes one item only which is a weekly skin assessment. The September 2011 treatment sheet for R18 does not include any pressure ulcer treatments. The Physician Orders Sheets for R18 for August and September 2011 do not include any orders to treat or protect pressure areas.

Nursing notes for R18 begin on 8/13/11. The only other note found in the record is an admission note of 8/5/11 on a Nursing Admission

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Assessment form. There is no other documentation on pressure ulcers or clarification of where it is located.

On 9/8/11 at 2:30 pm, E9 (CNA/Certified Nurse Aide) stated, "(R18) does have an area on her behind. It is covered with a (hydrocolloid dressing). At 2:35 pm on 9/8/11 E37 (CNA) stated, "I haven't taken care of (R18) today but she did have a (hydrocolloid dressing) on a pressure sore. It's on the fold of her buttocks."

At 2:50 pm on 9/8/11, E5 (MDS/Minimum Data Set Coordinator) stated, "The MDS is correct. (R18) was admitted with a pressure sore on her coccyx. (R18) has a (hydrocolloid dressing) on for protection."

A telephone order was received the evening of 9/8/11 at 4:00 pm which states "Order clarification. (Hydrocolloid dressing) to RIGHT gluteal fold for protection. (change every 72 hours)."

E34 (LPN/Licensed Practical Nurse) and E36 (CNA) were removing R18's pants on 9/9/11 at 9:40 am. There was no dressing noted on R18's right gluteal fold, ischial tuberosity or coccyx as described in the medical record. An area that was scarred and scabbed was noted on the left gluteal fold.

At 10:15 am on 9/9/11 Z4 (Z3's/R18's Medical Doctor's Medical Assistant) stated, "We got one notice on 8/5/11 of a pressure area to the right ischial tuberosity. There are no other calls. The doctor (Z3) hasn't seen (R18) yet."

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F 314	Continued From page 23 The facility policy titled, "Skin Management", dated February 2010, notes the following: 4. a. Residents with skin impairments will have appropriate interventions implemented to promote healing. b. a physician's order for treatment. c. Wound location and characteristics documented in the nursing notes. 5. In addition, the following forms are completed and placed in the treatment record: a. Weekly Pressure Ulcer Record 7. Wounds are tracked as acquired (developed in-house or admitted with and are assessed and documented on the Weekly Pressure Ulcer Record. These records are maintained in the resident's treatment record while in use. 8. The licensed Nurse will document daily monitoring of all pressure ulcers on the Treatment Administration Record (TAR). 9. A Physician's order will be written to monitor each ulcer and documentation on the TAR will reflect the status of the dressing, surrounding skin color and skin and pain associated with the wound. 10. The Nurse will record abnormalities or changes or non abnormalities or non changes to the dressing, skin or pain associated with the wound. 14. Ongoing monitoring and continuous quality improvement will be achieved by the interdisciplinary Team. 16. d. A Change of Condition form is to be completed and new physician's order obtained for new alterations noted as needed. 17. The nurse will assure that treatments, interventions, Care Plan and appropriate skin documentation records are initiated in a timely manor. 18. Pressure ulcers are measured and staged weekly.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		10/18/11

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unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide indication for the use of a antidepressants for one of nine residents (R8) sampled for psychotropic medication usage on the sample of sixteen. The facility failed to monitor for and prevent side effects including sedation resulting in falls for one of nine residents (R2) sampled for psychotropic medication usage on the sample of sixteen.

Findings include:

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1. R2's Face Sheet shows R2 was admitted 1-26-11 with a diagnosis of aggression.

R2's MAR (Medication Administration Record) dated 4-11 shows Lorazepam 1 ml (milliliter) IM (intramuscular) was given to R2 at 9:00 pm on 4-14-11. There is no nursing documentation in the nursing notes or on the MAR stating why this medication was being given. Behavior monitoring form for that time shows R2 was being combative with staff. R2's POS (Physician's Order Sheet) also shows R2 is receiving the antipsychotic Seroquel 100 mg (milligrams) twice a day, Aricept 10 mg once a day for Alzheimer's Disease, Lisinopril 20 gm twice a day for hypertension, and as needed Xanax for anxiety and Tylenol for pain.

Facility's Post Fall Review for R2 dated 4-15-11 states the following: (R2) was found lying supine in front of bathroom door with no socks or shoes on. After review of the fall information and interview of staff, it was determined (R2) required frequent monitoring and toileting after receiving Lorazepam for anxiety.

The Change of Condition report for the 4-15-11 fall states "the patient appears lethargic due to the Ativan...found lying in supine position in front of his bathroom. (R2) had the top sheet et (and) only a pull up on. (R2) was very drowsy. (R2) had received Ativan 1 mg IM at approximately 9 PM on 4-14-11 due to increased combativeness."

Nursing notes dated 4-15-11 at 12:00 am states R2 was found lying in front of the bathroom on the floor. It continues that R2 was lifted back to bed with a mechanical lift and four staff

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F 329	Continued From page 26 members. R2 had been given Lorazepam 1 mg IM at 9:00 pm due to combativeness towards staff. Nursing note states R2 did not respond verbally or open his eyes and neuro checks were implemented in case R2 hit R2's head. Nursing note at 2:45 am stated R2 more resistant but still under the influence of the Lorazepam. The behavior listed on behavior report for 4-15-11 is hitting at staff. Nursing notes dated 4-15-11 at 4:30 pm state R2's physician was notified of R2 striking at staff and inappropriate touching. Orders for the antipsychotic Haldol 5 mg four times a day were obtained. R2's POS (Physician Order Sheet) for 4-11 shows R2 was already receiving the antipsychotic Seroquel 100 mg twice a day and the anxiolytic Xanax 0.25 mg every 2 - 4 hours as needed for anxiety. Nursing notes dated 4-19-11 at 1130 stated R2's physician was notified of excessive drooling which is a side effect of the Haldol. Nursing notes at 11:35 pm show R2 requiring two staff to assist R2 with ambulation and an increase in shakiness. Nursing notes dated 4-21-11 at 10:30 pm stated R2 was having increased difficulty with standing steady. Nursing notes dated 4-23-11 at 10:30 pm state R2 was transferring poorly and voice was much weaker and softer. Physician's order dated 4-21-11 stated to decrease the Haldol to 5 mg twice a day instead of four times a day. Nursing notes dated 5-28-11 at 2:00 pm state R2 was asleep most of the day and could not stay awake long enough to "eat a meal." Note continues that R2's visitor requested a wheelchair since it was unsafe for R2 to walk.	F 329		

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Nursing notes dated 6-3-11 show R2 went out to see a psychiatrist. Orders were received to discontinue all Haldol. Psychiatrist note dated 6-3-11 states to discontinue Haldol 5 mg twice a day and Haldol 2 mg as needed. The note states to use behavioral interventions, Haldol 0.5 mg every eight hours as needed, fall precautions and observe for sedation. The note states to continue Seroquel 100 mg twice a day.

A Change of Condition note and Post Fall Review dated 6-5-11 states R2 fell out of wheelchair and that R2 appears "more confused." Nursing notes dated 6-7-11 and 6-8-11 state all of R2's Haldol orders were discontinued along with a antidepressant Lexapro. The antidepressant Zoloft 25 mg every day was ordered.

A Change of Condition note and Post Fall Review dated 6-8-11 at 3:45 pm show R2 fell next to R2's wheelchair. The investigation determined R2 was confused and refusing to stay seated and could benefit from an alarm placement. R2's MAR shows Xanax 0.25 mg was given at 6-8-11 at 4 pm and 8 pm.

Nursing notes dated 6-10-11 stated R2 was unsteady and weak. Nursing note dated 6-11-11 states R2 was attempting to stand and ambulate independently, gait not steady. Nursing notes dated 6-12-11 at 10:00 pm state R2 was given Xanax for "some agitation."

A Change of Condition note and post Fall Review dated 6-13-11 at 2:40 am, states R2 was attempting to go to the bathroom, was incontinent and slipped in urine and fell. Notes show neuro

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F 329	Continued From page 28 checks were once again implemented. Nursing notes dated 6-13, 6-14, and 6-16-11 show R2 having increased anxiety, agitation and sexually inappropriate. On 6-13-11 at 11:30 am, 6-14-11 at 3:30 am and 6-16-11 at 8:30 am, R2 was given Xanax 0.25 mg. A Change of Condition note and post Fall Review dated 6-17-11 at 12:00 am states R2 was found on the floor next to bed face down with blood coming from laceration to forehead and bridge of nose. The review states R2 was sent to the hospital and returned with sutures to the head. Nursing notes from 6-17-11 to 7-2-11 show R2 continued to decline and expired on 7-2-11. R2's Certificate of Death states Cause of Death is Alzheimer's Disease. R2's care plan for the "administration of psychoactive medications" initially dated 3-1-11 states to review meds the interdisciplinary team, observe for side effects, observe for effectiveness and document, psych services as ordered and then give medications as per doctor's orders. R2's care plan initiated 2-8-11 states R2 is socially inappropriate, resist cares, and make sexual comments and behaviors related to Dementia with Behaviors. The care plan contains interventions related to R2's behaviors. R2's Behavior Detail Report details behaviors but does not include interventions tried by facility before medications administered. Nursing notes for that time do contain some instances of interventions.	F 329		

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F 329	Continued From page 29 2. The Physician Order Sheet dated September 2011 lists medications for R8 including Restoril 15 mg (milligrams) one to two capsules by mouth at bed time as needed and Paxil 20 mg one tablet by mouth at bedtime. The September 2011 Medication Administration Record for R8 shows the daily administration of the Paxil and the as needed use of the Restoril. R8's entire medical record was reviewed. No supporting diagnosis/indication for use or rational by R8's physician was found for the use of these psychotropic medications. On 09/08/2011 at 10:40 AM, E5 (Minimum Data Set Coordinator/Registered Professional Nurse) stated, "You know (R8) came to us with those medications. I don't know anymore about it. I'll take a look and try to find more information." On 09/08/2011 at 08:15 AM E1 (Administrator) stated, "We cannot find a diagnosis or progress notes in the chart for the medications. We have a call in to the doctor about it."	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to administer medications per physician's order giving 20 times the ordered dose of Morphine to R2, one of 16 residents reviewed on	F 333		10/18/11

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F 333	Continued From page 30 the sample of 16. Findings include: On 9-13-11 at 10:30 am, E34 (LPN-Licensed Practical Nurse) stated the following: On 7-2-11 R2 was "not with it at all." Family requested R2's physician be called. E34 contacted R2's physician (E33) who gave an order for Morphine Sulfate 2 mg (milligrams) to be given orally for comfort. E34 stated E34 gave the medication about 1:40 pm and then realized E34 had given R2 Morphine Sulfate 40 mg instead of 2 mg as ordered by R2's physician. E34 (LPN) stated E34 contacted R2's family who was at the bedside, E3 (ADON/Assistant Director of Nursing at that time) and tried to call R2's physician. E34 stated E3 (ADON) talked with R2's family about the error and the effects of using Narcan to reverse the effects of the Morphine overdose. R2's family decided not to give the Narcan. E34 stated R2 passed away sometime around 4:00 pm that afternoon. Facility incident report dated 7-2-11 stated the following: "Resident (R2) was actively dying. (R2) became restless and was grimacing upon movement. (E33/R2's physician) was notified and order was given for 2 mg of P.O. (orally) Morphine Sulfate every 15 min until pain subsides. Medication available was 20 mg/ml. Medication administered was 2 ml (milliliters) which was equal to 40 mg. (R33) was notified of medication variance and order was received for Narcan 0.4 mg prn (as needed) for respiratory depression. Family was at bedside and requested that Narcan not be give. (E33) was aware and instructed nurse to keep order and administer if	F 333		

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F 333	Continued From page 31 family changed their minds." On 9-13-11 at 1:10 pm, E33 (R2's physician) stated the following: E33 was called because R2 was having trouble breathing and R2's family wanted comfort measures only for R2. E33 ordered 2 mg of Morphine Sulfate but the nurse gave 40 mg of Morphine instead. E33 ordered Narcan to reverse the effects of the Morphine. R2's family refused the Narcan. E33 was unable to say if the excess Morphine hastened R2's death, saying R2 died peacefully with R2's family beside R2. Facility's Medication Administration revised June 2008 states "Medications are administered in accordance with written orders of the attending physician. If a dose is inconsistent with the resident's age and condition or a medication order is inconsistent with the resident's current diagnosis or condition, contact the physician for clarification prior to administration of the medication...Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength and route." Pharmacy provided packet insert information for Morphine Sulfate states: "Morphine sulfate 100 mg per 5 ml (20 mg/ml) solution is indicated for the relief of moderate to severe acute and chronic pain in opioid-tolerant patients. Dosage and Administration: Morphine Sulfate Oral Solution: 10 to 20 mg every 4 hours as needed. Warnings and Precautions: Risk of Medication Errors: Use caution when prescribing, dispensing, and administering to avoid dosing errors due to confusion between different concentrations and between mg and ml, which could result in	F 333		

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F 333	Continued From page 32 accidental overdose and death. Respiratory depression: Increased risk in elderly, debilitated patients, those suffering from conditions accompanied by hypoxia, hypercapnia, or upper airway obstruction."	F 333		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to record pain assessments and administration of pain medications for one of five residents (R19) reviewed with pain issues in a total sample of 16. The facility failed to record in the resident's clinical record a thorough assessment for one of four residents (R16) reviewed with allegations of abuse. The facility failed to record medication not given per facility policy for two of 16 residents (R19 and R2)on the sample. Findings include:	F 514		10/18/11

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A policy dated June 2008 and titled Medication Administration states, "...Documentation: Record the name, dose, route, and time of the medication on the Medication Administration Record.... Initial the record after the medication is administered to the resident..." A policy dated February 2010 and titled Pain Management states, "... 6. The licensed nurse will implement a Pain Medication Administration Record in the Medication Administration Record (MAR) binder for documentation of pain, interventions, and outcomes.... 11. The licensed nurse, when administered narcotic pain medications, will record the drug administration on the Pain Medication Administration Record..."

1. A discharge summary from a local hospital dated 8/30/11 states R19 was admitted to the local hospital after falling at home and fracturing the right humerus. The hospital discharge summary reports R19's pain was treated with around-the-clock Hydrocodone/Acetaminophen. The POS (Physician Order Sheet) dated 8/30/11 shows R19 was admitted on 8/30/11 with physician orders for Hydrocodone/Acetaminophen 10/650 mg (milligram) by mouth every four hours as needed around the clock not to exceed 4000 mg in 24 hours and Morphine Sulfate IR 15 mg by mouth three times a day as needed for severe pain.

The pharmacy Controlled Substance Records for R19's pain medication Hydrocodone/Acetaminophen 10/650 mg from 8/31/11 through 9/13/11 show 44 doses of Hydrocodone/Acetaminophen 10/650 mg were signed out on the pharmacy controlled substance

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F 514	Continued From page 34 records for administration to R19. R19's PRN (as needed medication) Administration Record from 8/31/11 through 9/13/11 shows only 24 of the 44 doses taken from the pharmacy supply were documented as administered to R19. R19's PRN Pain Medication Administration Record from 8/31/11 through 9/13/11 shows R19 was assessed for pain a total of 32 times. The pharmacy Controlled Substance Record for R19's pain medication Morphine Sulfate IR 15 mg from 8/31/11 through 9/13/11 shows two doses of Morphine Sulfate IR were signed out on the pharmacy controlled substance records for administration to R19, one on 9/01/11 and one on 9/07/11. R19's PRN (as needed medication) Administration Record from 8/31/11 through 9/13/11 shows an incomplete entry on 9/01/11 without initials from a licensed nurse to indicate the Morphine was administered to R19. R19's PRN (as needed medication) Administration Record has no documentation that indicates R19 received the dose of Morphine Sulfate signed out for R19 on 9/07/11. The PRN (as needed) Pain Medication Administration Record for R19's Morphine from 9/01/11 through 9/13/11 shows only one pain assessment for th entire time frame. On 9/13/11 at 1:20 p.m., E32 (LPN/Licensed Practical Nurse) stated, "... (On the Pain Medication Administration Record) we only put	F 514		

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something down if they (the resident) got pain medication....We are suppose to circle it and write on the back of the MAR (Medication Administration Record) why it wasn't given."

2. A hand written statement dated 4/28/11 and signed by E23 (CNA/Certified Nursing Assistant) states while (E23 and E24 both CNAs) were getting (R16) on the toilet, (R16) didn't set on the toilet right....(E24) said, 'Damn it (R16) stand up.' ... (R15/R16's roommate) said (R15) thought (E24) was a little short with (R16). (E23) went to (E22/RN/Registered Nurse) and reported the incident..."

An abuse allegation investigation file dated 4/28/11 includes a Concern From signed by E22 (RN) and dated 4/28/11. The Concern Form states "(E23 and E24) were changing (R16) and when transferring (R16) (E24) said, 'God damn it (R16) stand up.' Then (E24) proceeded to say that (E24's) sick of the shit and (R16) not wanting to help."

A typed written investigation summary written by E1 (Administrator) dated 4/29/11 indicates the incident occurred "around 3:00 a.m. to 4:00 a.m.." During the investigation, E23 (CNA), E22 (RN), R15 (R16's roommate), and R16 were interviewed. The report states R16 did not recall the incident but R15 (R16's roommate) did. R15 reported she heard (E24 - CNA) say to (R16) 'stand up damn it!.' R15 reported E24's tone of voice was very rough and (R15) was very upset by it.

R16's nurses notes do not include an entry on 4/28/11 to indicate R16 was assessed for

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F 514	Continued From page 36 possible injury after the allegation of abuse. E1's (Administrator) investigative file contains an unsigned Body Check Worksheet dated 4/28/11 at 7:00 a.m. for R16's skin condition and wound assessment. R16's clinical record does not include a thorough assessment of R16 after the abuse allegation. 3. A telephone order dated 6-8-11 for R2 states "Zoloft 25 mg (milligrams) PO (by mouth) daily." R2's for 6-11 states Zoloft 25 mg PO daily. Most doses dated 6-9-11 through 6-30-11 are circled as not given. On the back of the MAR (Medication Administration Record) for dates 6-9-11 through 6-16-11 it states "not available" for the reason the medication was not given. From 6-17-11 through 6-30-11 the medication was initialed 14 times, and not circled four of the 14 times. There is no explanation in the nursing notes or on the MAR for these times the medication was not given.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS. 300.1210a)d)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	F9999		

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allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

THIS REQUIREMENT IS NOT MET AS EVIDENCED BY:

Based on observation, record review and interview, the facility failed to identify new pressure ulcers, failed to monitor and promote healing of pressure ulcers, failed to notify the physician of the need for revisions of treatment

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for one of one residents (R4) who acquired pressure sores in the facility, and failed to monitor, evaluate, and treat one of three residents (R18) admitted with pressure ulcers on the sample of 16. R4 developed four unstageable pressure sores while residing in the facility.

Findings include:

1. R4's admission face sheet dated 2/12/10, indicates R4 to be 88 years of age with Diagnoses including: Esophogeal Reflux, Anxiety, and History of Fractured Neck of Femur. R4's MDS (Minimum Data Set) dated 8/27/11 notes R4 to be moderately impaired in cognition. The MDS reports no current pressure ulcers. The 8/20/11 care plan for R4 indicates a potential for pressure sores. It does not document any current pressure ulcers. A pressure ulcer risk predicting tool dated 8/19/11 notes R4 to score a 17. The tool scores R4 a mild risk at 17 in a scale of 15-18.

The facility weekly pressure ulcer log provided by the facility as current and dated August 2011 includes R4 as having a pressure ulcer on both the right and the left heel.

R4's nursing notes contain a change of condition form dated 8/21/11. The form reports to E33 (R4's medical doctor) a bruise on the left heel that hurts when putting on a shoe. The assessment states: "(R4) appears normal for self." the form states at 9:15 am on 8/21/11 an area measuring 2 cm (centimeters) by 1 cm on R4's left heel. The center of the area is dark purple and the area around it is dark red. No warmth or swelling noted at the site. (R4) complains of pain when area is touched. Will continue to monitor." No response

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was received observed from E33. No documentation from staff that E33 was contacted again that day.

On 8/27/11, six days later, a second change of condition form is noted. This form reports pressure sores on bilateral heels were reported to E33 (R4's Medical Doctor) at 4:00 pm on 8/27/11. The nursing note of 8/29/11 at 3:00 pm, two days after reporting bilateral pressure ulcers and eight days after reporting a bruise to the left heel, states a new order was received from E33 (R4's Medical Doctor) for a treatment of a "preparation pad" wipe to the areas. E27 (RN/Registered Nurse) was asked on 9/7/11 at 2:00 pm why there was a two day delay after E27 (RN) notified the physician of the pressure ulcers. E27 (RN) replied, "I don't know why, but I do know (E33) was here in the room across from (R4) that weekend with his family. Oh, and that preparation pad for (R4's) heels, is used to toughen the skin. I think it is too late for that. I will let you know when I get the supplies to do his treatment." E27 (RN) did not return this day with any notification.

A weekly pressure ulcer record reports the date of onset to the outer right heel as 8/27/11. It then documents an assessment on 8/29/11 which reads: "Outer right heel measures 4 cm (centimeters) x 3 cm bright read to dark purple with blister on top and unable to obtain depth. Boots applied when up in wheelchair." Also documented for 8/27/11 is an area to the left outer heel: "Area 4 cm x 3.5 cm with 0.1 cm depth open with serous drainage. (R4) moving feet on bed. Boots applied when in wheelchair."

On 9/8/11 at 11:05 am E27 (RN/Registered

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F9999	Continued From page 40 Nurse) and E30 (CNA/Certified Nurse Aide) were preparing R4 to do treatments on R4's bilateral heels. E27 (RN) stated, "Here is the current treatment sheet for (R4). I didn't get to this yesterday, but they did have (E35/LPN/Licensed Practical Nurse) measured (R4's) ulcers last night (9/7/11). Now (R4) has a new order for antibiotic ointment to the ulcer on the right outer heel because it has opened up." The padded protected boot was removed from R4's left foot. The gauze dressing was off of the ulcer located on the heel and was approximately three inches above R4's ankle. The ulcer was was not covered. E27 (RN) measured this ulcer as 6 cm long by 4 cm wide with the depth undeterminable. The ulcer was dark purple and black with some fluid noted above the discoloration. E27 (RN) began to apply the dressing. A black area was slightly visible on the opposite side of the left heel. E27 (RN) was then asked to turn R4 so that the opposite side could be observed for any other ulcers. E27 (RN) stated, "No, there aren't any other areas." Upon turning R4, a second ulcer was present on the inner lateral area of the left heel. E27 (RN) stated, "Well, there is another one." E30 (CNA) rolled his eyes and stated, "He (R4) used to wear shoes before this happened." E27 (RN) measured the area as 5 cm long x 3.3 cm wide with undeterminable depth. The area was purple and black with some fluid filled areas noted. E27 (RN) wiped the area. Serosanguinous drainage was present on the wipe. E27 (RN) then removed the dressing from the right heel. The area had some black necrotic tissue at the edge of an open area, in addition to dark purple, dark red, and some fluid filled areas on top of the discolored areas. The entire area appeared to be approximately 7 cm long x 6 cm wide. E27 (RN)	F9999		

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and E30 (CNA) were asked to roll R4 over to observe the lateral side of the right foot. E27 (CNA) stated, "I'm sure there are no others." Once turned, a second area, totally black in color, approximately dime size, was noted to the lateral aspect of the right foot. E27 (RN) measured the area as 1 cm x 1 cm with depth undeterminable. E27 (RN) stated, "(E35/LPN/Licensed Practical Nurse) was told to measure these last night (9/7/11) after you had asked to see them." E35 (LPN) documented on a weekly pressure ulcer record, dated 9/7/11, "Area to the outer right heel as going from 4 cm x 3 cm on 8/29/11 to 6 cm x 7 cm on 9/7/11. Included in the area is an open area measuring 1.3 cm x 2 cm. Treatment received to use (antibiotic ointment) and dressing two times daily." E27 (RN) was asked if E35 (LPN) had found and measured the two new areas. E27 (RN) stated, "Not on the treatment sheet. It only has the two areas."

E35 (LPN) stated on 9/8/11 at 2:05 PM, "I've only been here three days. I was just told to measure (R4's) sore on the one foot and nobody else. It was just one area."

During interview with E2 (DON/Director of Nursing) on 9/9/11 at 10:10 am, E2 (DON) stated, " I did an investigation and I believe that (R4's) family brought in some cheap shoes that didn't fit right."

Z1 (E33/R4's Medical Doctor's Nurse) stated, "There were four pressure sores to start with. I don't have any dates but our first order was for (antibiotic ointment) for (R4) on September 1st or 2nd and then an order for a skin preparation to

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toughen the skin." Z1 was informed that the facility documented a change of condition notice dated 8/21/11 of a bruise to the left heel and another change notice dated 8/27/11 for pressure ulcers to R4's bilateral heels, one each. Z1 stated, "Oh, yes, but that probably wasn't a bruise on the first heel since the next was pressure sores." Z1 was asked why it took two more days to get a treatment order for the ulcers requested on 8/27/11 and received on 8/29/11. Z1 stated, "The doctor (E33) was off on vacation from 8/22/11-8/26/11. (E33) is the medical director, he does take call for himself but he was off somewhere that he had no reception on his phone. I really can't give you any other dates about how or when the sores developed."

The 8/1/11 to 8/31/11 treatment administration includes orders dated 8/29/11 to apply (skin preparation pad) treatments to bilateral heels BID (two times a day). The treatment sheet shows that the treatment was not begun until 8/31/11, four days after the doctor was notified of bilateral pressure ulcers to the heels and ten days after the first change of condition documentation for the left heel.

2. R18's admission face sheet dated 8/5/11 indicates that R18 is 68 years of age with Diagnoses including: Diabetes, Cerebral Palsy and History of Septic Right Hip. R18's MDS dated 8/15/11 reports R18 to have one stage two pressure ulcer. Interim care plan for R18 dated 8/5/11 states "Wound will show signs of healing with area decreasing in overall size and depth by next review." Nursing Admission Assessment dated 8/5/11 marks an area on R18's coccyx of

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F9999	Continued From page 43 1.5 cm (centimeters) x (by) 1 cm. It includes a pressure sore risk tool that scores her a 16 for a total score equally 15-18 as a mild risk. The Medical Nutritional Therapy Assessment dated 8/5/11 (on admission) notes the following: Skin condition: Pressure Ulcer Right Intragluteal Cleft. Admission sheets from R18's transferring facility dated 7/1/11 through 7/31/11 note a treatment to the Right Ischial Tuberosity daily (pressure ulcer hydrocolloid dressing) to protect. A weekly pressure ulcer record dated 8/5/11 notes a stage II area on the "coccyx admit" measures 1.5 cm x 1 cm open area. R18's treatment record for 8/1/11 through 8/31/11 includes one item only which is a weekly skin assessment. The September 2011 treatment sheet for R18 does not include any pressure ulcer treatments. The Physician Orders Sheets for R18 for August and September 2011 do not include any orders to treat or protect pressure areas. Nursing notes for R18 begin on 8/13/11. The only other note found in the record is an admission note of 8/5/11 on a Nursing Admission Assessment form. There is no other documentation on pressure ulcers or clarification of where it is located. On 9/8/11 at 2:30 pm, E9 (CNA/Certified Nurse Aide) stated, "(R18) does have an area on her behind. It is covered with a (hydrocolloid dressing). At 2:35 pm on 9/8/11 E37 (CNA) stated, "I haven't taken care of (R18) today but she did have a (hydrocolloid dressing) on a pressure sore. It's on the fold of her buttocks."	F9999		

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F9999	Continued From page 44 At 2:50 pm on 9/8/11, E5 (MDS/Minimum Data Set Coordinator) stated, "The MDS is correct. (R18) was admitted with a pressure sore on her coccyx. (R18) has a (hydrocolloid dressing) on for protection." A telephone order was received the evening of 9/8/11 at 4:00 pm which states "Order clarification. (Hydrocolloid dressing) to RIGHT gluteal fold for protection. (change every 72 hours)." E34 (LPN/Licensed Practical Nurse) and E36 (CNA) were removing R18's pants on 9/9/11 at 9:40 am. There was no dressing noted on R18's right gluteal fold, ischial tuberosity or coccyx as described in the medical record. An area that was scarred and scabbed was noted on the left gluteal fold. At 10:15 am on 9/9/11 Z4 (Z3's/R18's Medical Doctor's Medical Assistant) stated, "We got one notice on 8/5/11 of a pressure area to the right ischial tuberosity. There are no other calls. The doctor (Z3) hasn't seen (R18) yet." The facility policy titled, "Skin Management", dated February 2010, notes the following: 4. a. Residents with skin impairments will have appropriate interventions implemented to promote healing. b. a physician's order for treatment. c. Wound location and characteristics documented in the nursing notes. 5. In addition, the following forms are completed and placed in the treatment record: a. Weekly Pressure Ulcer Record 7. Wounds are tracked as acquired (developed in-house or admitted with and are	F9999		

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F9999	Continued From page 45 assessed and documented on the Weekly Pressure Ulcer Record. These records are maintained in the resident's treatment record while in use. 8. The licensed Nurse will document daily monitoring of all pressure ulcers on the Treatment Administration Record (TAR). 9. A Physician's order will be written to monitor each ulcer and documentation on the TAR will reflect the status of the dressing, surrounding skin color and skin and pain associated with the wound. 10. The Nurse will record abnormalities or changes or non abnormalities or non changes to the dressing, skin or pain associated with the wound. 14. Ongoing monitoring and continuous quality improvement will be achieved by the interdisciplinary Team. 16. d. A Change of Condition form is to be completed and new physician's order obtained for new alterations noted as needed. 17. The nurse will assure that treatments, interventions, Care Plan and appropriate skin documentation records are initiated in a timely manor. 18. Pressure ulcers are measured and staged weekly. (B)	F9999		